Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN459ASC	A. BUILDING _____ B. WING _____	02/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARSON ENDOSCOPY CENTER	707 N MINNESOTA CARSON CITY, NV 89703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 00	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a focused State Licensure survey conducted at your facility on 2/21/08. The survey was conducted using Nevada Administrative Code (NAC) 449, Surgical Centers for Ambulatory Patients. Findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions, or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	A 00		
A 69	NAC 449.9812 Program for Quality Assurance 2. The program for quality assurance must include, without limitation: (g) Procedures for identifying and addressing any problems or concerns related to the care provided to patients using the medical records of the center and any other sources of data that may be useful to identify previously unrecognized concerns, and for assessing the frequency, severity and sources of suspected problems and concerns. The procedures must include, without limitation, procedures for assessing: (6) The procedures used to control infection. This Regulation is not met as evidenced by: Based on observation, interview, and review of policy and procedures, it was determined the facility failed to follow procedures to control infections by failing to follow the manufacturer's recommendations of not reusing single use	A 69		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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A 69	Continued From page 1 items. On 2/21/08, a colonoscopy procedure was observed. At the end of the procedure, the endoscopy technician placed the scope, wires, and 60 cubic centimeter (cc) syringe used during the procedure into a plastic container. The endoscopy technician removed the suction canister and placed the suction canister on top of the plastic container and carried the plastic container into the sterile processing room. The endoscopy technician was observed to empty the suction canister into the hopper, rinse it out with water, and carry it back into the procedure room. She then re-connected the suction tubing to the suction canister. A new patient was brought into the procedure room with the reconnected used suction canister. On 2/21/08, at 10:45 AM, a telephone interview was conducted with a customer service representative from the distributor of the hi-flow rigid suction canisters the facility was using. She stated that the hi-flow rigid suction canisters were for single patient use. She stated that they could not be sterilized. She stated that sterilization would compromise the integrity of the filter. She stated that the filter was to prevent bacteria, aerolized microorganisms, and particulate matter from entering the suction tubing. She stated that the manufacturer did not recommend multiple patient use because of the risk of possible contamination between patients. On 2/21/08, at approximately 11:00 AM, the endoscopy technician was interviewed. She confirmed that after she emptied the suction canister, she rinsed it out and re-connected it to the suction tubing. The suction cannister would then be used on a different patient. She stated	A 69		

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A 69	Continued From page 2 that the suction canisters were used until the suction no longer functioned. She stated that the suction canisters were sterilized with Rapicide at the end of each day. Per the manufacturer's website, Rapicide is a ready to use liquid chemical germicide solution. Rapicide is labeled and intended for the high-level disinfection or sterilization of critical and semi-critical clean, heat-sensitive medical devices. In summary, it was determined that the facility would use a suction canister which had been contaminated with one patient's body fluids, rinse it out with water, and then reuse it on a different patient. The suction canisters were processed with Rapicide at the end of each day. On 2/21/08, the facility's policy and procedures were reviewed. The policy for infection control did not address the use of the single use patient suction canister for multiple patients. On 2/21/08, a large container full of 60 cubic centimeter (cc) syringes were observed in the instrument decontamination area. The syringes were open and not in their original packaging. The instrument processing technician stated that these were the syringes used on patients to flush their endoscopes during endoscopy procedures. She stated that the syringes were processed in the custom ultrasonics scope reprocessor after they were used on patients. The instructions on a 60 cc syringe's original packaging revealed that the syringe was not to be reused. Severity: 2/ Scope: 3	A 69		
A153	NAC 449.9895 Sterilization 3. Instructions for operating any autoclave or sterilizer must be posted near the equipment, and	A153		

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A153	Continued From page 3 this equipment must be maintained in a safe operating condition. This Regulation is not met as evidenced by: Based on interview it was determined the facility failed to follow all of the manufacturer's maintenance instructions to ensure the autoclave was maintained in a safe operating condition. On 2/21/08, the autoclave's manufacturer's instructions were reviewed. The operator maintenance instructions revealed that, "The pressure relief valve must be checked each month by a qualified person to be sure that the relief valve is functioning properly." There was no evidence found that this was being done. On 2/21/08, it was confirmed with the clinical director that this was not being done. Severity: 2/ Scope: 3	A153		